# PREPARATION AND MAILING INSTRUCTIONS
# FORM DPA 1409
# PRIOR APPROVAL REQUEST

Form DPA 1409, Prior Approval Request, is to be submitted by the physician for certain specified services which he will personally provide in order for the services to qualify for reimbursement. Services requiring prior approval are identified in specific policy given in Handbook Section II, Chapter 200.

Form DPA 1409 is a three-part carbon-interleaf form. A facsimile of the form is included in this appendix.

INSTRUCTIONS FOR COMPLETION

The form is to be either typewritten or legibly hand printed. The left hand column of the instructions below identifies mandatory items which must be completed. The following categories apply:

| | |
|---|---|
| Not Required | Leave blank. |
| Required | Entry always required. |
| Conditionally Required | Fields which require completion based on an entry in another field. Conditions of the requirement are identified in the instruction text. |

The following explanation and instructions for completion of the form correspond with the numbered entry fields:

| COMPLETION STATUS | DATA ELEMENT |
|---|---|
| Not Required | Document Control Number - Leave blank. This field will be completed by the Department upon receipt of the form. |
| Not Required | 1. Trans Code (Transaction Code) - Leave blank. This field identifies Department action on processing the request. |
| Not Required | 2. Prior Approval Number - Leave blank. The Department will assign a unique number which is to be used by the physician to submit charges for the approved service. The Department will use this number to cross-check the physician's claim against its record of approved services. |

| **COMPLETION STATUS** | **DATA ELEMENT** |
|---|---|
| Required | 3. Case Name - Enter the case name from the patient's MediPlan Card. The case name appears on the card in conjunction with the mailing address. |
| Required | 4. Recipient Name - Enter the name of the patient for whom the service is requested. The patient's name appears on the MediPlan Card. |
| Required | 5. Recipient Number - Enter the nine-digit recipient number assigned to the patient for whom the service is requested. This number is found to the right of the patient's name on the MediPlan Card. |
| Required | 6. Birth date - Enter the patient's birth date. |
| Conditionally Required | 7. Inst Set (Institutional Setting) - An entry in this field is required only when the patient resides in a group care facility. Enter one of the following codes: (H) Long-Term Care Facility; (I) Sheltered Care Facility: (L) Other Location, e.g., State Hospital or Rehabilitation Facility. |
| Required | 8. Case Identification Number - Enter the Case Identification Number from the patient's MediPlan Card. This number is found in the primary portion (right side) of the card immediately above the case name and mailing address. The Case Identification Number is to be used by the physician as a reference when contacting either the local Public Aid office or the Bureau of Comprehensive Health Services (as appropriate) concerning the status of the request. |
| Required | 9. Recipient Street Address - Enter the recipient's current street address. The Department will use this information to mail directly to the recipient-patient the "Notice of Decision on Request for Medical Service/Item". |
| Conditionally Required | 10. Facility Name - An entry in this field is required only when an entry appears in item 7 above. |
| Required | 11. Recipient City - Refer to item 9 above. |
| Conditionally Required | 12. Facility City - An entry in this field is required only when an entry appears in items 7 and 10. |
| Required | 13. Requesting Provider Name - Enter the name of the physician who is requesting the service. |

**COMPLETION STATUS** **DATA ELEMENT**

| | |
|---|---|
| Required | 14. Request Prov No (Requesting Provider Number) - Enter the physician's Provider Number exactly as shown on the Provider Information Sheet. |
| Required | 15. Provider Street Address - Enter the physician's street address. The Department will return a copy of the processed (approved/denied) request. |
| Required | 16. Provider Telephone - Enter the telephone number of the physician's office. The information is helpful in instances where the Department needs additional information in order to act upon the request. |
| Required | 17. Provider City, State, Zip - Refer to entry field 15. |
| Not Required | 24. Approving Authority - Leave blank. |
| Not Required | 25. Disposition Date - Leave blank. |
| Not Required | 26. Approving Authority Signature - Leave blank. |
| Not Required | 27. Receipt Date - Leave blank. |
| | 28. Service Sections - The form provides space to request a maximum of three services. When more than three services are requested, a second form must be completed.<br><br>The format of each service section also allows for separate approval or denial of each service requested.<br><br>Instructions for completion of entry fields contained within a service section follows: |
| Conditionally Required | Req Proc Code (Requested Procedure Code) - Enter the appropriate code which identifies the procedure for which approval is requested. For drug items or medical supplies/equipment, leave blank. |
| Required | Req Qty (Requested Quantity) - Enter the number of times the service is to be performed. |
| Required | Prov Charge (Provider Charge) - Enter the physician's charge for the service. |

| **COMPLETION STATUS** | **DATA ELEMENT** |
|---|---|
| Required | Description - Briefly describe the procedure to be performed. If additional space is needed, provide the information on letterhead paper, identifying the patient name, case name, and case identification number. |
| Not Required | Disposition Status - Leave blank. A one-digit number will be used by the approving authority to identify approval/denial status of the request. 0 - denial; 1 - approval. |
| Not Required | Appv Proc Code (Approved Procedure Code) - Leave blank. The approved procedure code will be entered by the approving authority. This code may differ from the procedure code requested. |
| Not Required | Appv Qty (Approved Quantity) - Leave blank. Identifies the quantity approved by the approving authority. This may differ from the quantity requested. |
| Not Required | Unit Amount - Leave blank. Not applicable to physician services. |
| Not Required | Total Amount - Leave blank. Not applicable to physician services. |
| Not Required | Begin Date - Leave blank. This is the earliest date the service may be provided. |
| Not Required | End Date - Leave blank. This is the last date on which the service may be provided. |
| Not Required | Occur Limits (Occurrence Limits) - Leave blank. An entry here by the approving authority specifies the number of times the procedure may be performed within a given number of days. |
| Not Required | Reason For Denial - Leave blank. The written reason why approval was not granted. |
| Required | 29. Medical Necessity - The physician is to enter a statement as to the need for the service(s) requested. If additional space is needed, provide the information on letterhead paper, identifying the patient name, case name, and case identification number. |
| Required | 30. Supplying Provider Signature - The form is to be signed in ink by the individual who is to provide the service. |
| Required | 31. Request Date - Enter the date the form is signed. |

MAILING INSTRUCTIONS

LEAVE ALL COPIES INTACT - DO NOT REMOVE CARBON PAPER

Before mailing, carefully review the request for completeness and accuracy. The request is to be mailed to the appropriate approving authority as shown below:

| Type of Service | | Approval Authority Mailing Address |
|---|---|---|
| 1.Specified optical materials and services | Mail to: | Illinois Department of Public Aid<br>Bureau of Comprehensive Health Services<br>201 South Grand Avenue, East<br>Springfield, Illinois 62763-0001 |
| 2.Drug items not included in the Department's Drug Manual | Mail to: | Illinois Department of Public Aid<br>ATTN: Drug Unit Prior Approval<br>Post Office Box 19117<br>Springfield, Illinois 62794-9117 |
| 3.Drug quantities in excess of the maximum allowable quantity | Mail to: | (See item 2, mailing address) |
| 4.All other physician services requiring prior approval | Mail to: | Illinois Department of Public Aid<br>Bureau of Comprehensive Health Services<br>201 South Grand Avenue, East<br>Springfield, Illinois 62763-0001<br><br>-or-<br><br>Use pre-addressed envelopes, Form DPA 1414, Special Approval Envelope, which are provided by the Department for this purpose. |

NOTIFICATION OF DECISION

Notification of approval or denial will be sent to the physician. The service is not to be billed until the approval notification is received.